



Holyoke Medical Center

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May 23, 2012

Aron Boros
Commissioner
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Dear Commissioner Boros:

On behalf of our Board of Directors, employees, nurses and volunteers, affiliated organizations and the entire Holyoke Medical Center (HMC) community, I want to thank you for the opportunity to submit written testimony to the Division of Health Care Finance and Policy in response to your recent letter and in connection with the upcoming public hearings concerning health care provider and insurer costs and cost trends.

We look forward to continuing work with you to confront and resolve the significant challenge of understanding the cost trends faced in the Commonwealth of Massachusetts.

Attached are HMC's responses to the questions posed by the Division and the Office of the Attorney General.

To the best of my knowledge, the information provided in this testimony is factual and accurate given the information available at this time. This testimony is signed under the pains and penalties of perjury.

Sincerely,

Hank J. Porten
President & CEO

Exhibit B: Questions for Written Testimony

HOLYOKE MEDICAL CENTER TESTIMONY

Questions

Trends in Premiums and Costs

1. *After reviewing the preliminary reports, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.*

RESPONSE:

The report concludes, in part, that despite the deceleration of premium growth and decreasing trend in medical expenses, small employers and individuals continue to face higher premium increases and purchase lower value insurance products. There may be several factors causing this, including the continued under funding by government payers, including Medicare and Medicaid, as well as the lack of purchasing power of individuals and small employers. As governmental payers continue to try and reduce healthcare costs by holding rates artificially low, those providers with the necessary market clout continue to demand relatively higher reimbursements to offset these losses. Although large employers have the ability to resist higher premium increases, small employers and individuals do not have the same negotiation power.

HMC agrees that there is an increase in the buying down of coverage. HMC is seeing an increase in the move toward higher deductible and co-insurance by its patients. This is most likely due to the fact that most employers in the Holyoke area are smaller and, as such, tend to purchase higher deductible and co-insurance plans. As a result of the recent trend in high-deductible, high co-pay plans, HMC has seen an increase in patient bad debts related to these increased co-pays and deductibles. This increase has caused HMC to incur additional administrative costs, in addition to the lost reimbursement, in hiring a third-party vendor that specializes in the collection of self-pay accounts. HMC believes that providers would see a significant decrease in patient bad debts as well as an increase in reimbursement if the insurance companies that are selling these high deductible and high co-payment plans were responsible for their collection. HMC does not accept the argument presented by the health insurance industry that they are not set up to collect these payments, since they are already adjudicating these claims and determining the amount owed as well as collecting the premiums associated with these insurance policies.

2. *What specific actions has your organization taken to reduce the cost of services? Please also describe what impact, if any, these strategies have had on service quality and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?*

RESPONSE:

HMC has reduced staff and continues to monitor its expenses closely. HMC has been moving as quickly as possible toward the use of electronic medical records and other technologies to be able to maximize efficiencies and improve patient care (HMC was number one out of the 58 participating hospitals in MA in the Stroke Collaborative Reaching for Excellence program). HMC wants to continue to improve the efficiencies of the care it provides through the continued implementation of appropriate technologies and the recruitment of badly needed primary and specialist physicians to the community.

Additionally, over the last several years, HMC has taken the following measures to reduce costs:

- Layoffs
 - Staff has taken days off without pay (furlough days)
 - Increased the employee contributions to their health coverage
 - Froze the Defined Benefit Pension Plan and has not made any contributions to the defined contribution plan
 - Eliminated support departments such as Marketing
 - Conducted several LEAN projects to identify and improve patient flow, eliminate redundancies, minimize waste and reduce patient and employee risks
 - Delayed facility upgrades and capital purchases due to financial constraints
 - Replaced some vacant positions with lower cost staff where possible and appropriate
3. *When calculating Total Medical Expense (TME), we found a wide variation in health-status adjusted TME by provider group and that a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please share your organization's reaction to these findings.*

RESPONSE:

As noted in question 1 above, one cause of the wide variation in Total Medical Expense (TME) and the cluster of patients in the most expensive providers could be due to the ability of these large provider groups to demand higher reimbursement. As a result of the higher reimbursements, these providers are able to spend higher amounts on marketing and infrastructure focused on attracting patients as "centers of excellence," which may or may not be supported by the care provided.

The clustering of patients may also be due to the size of the organization and/or market clout.

4. *Please explain the main factors for any changes in annual TME that your organization has experienced. What specific efforts has your organization made to lower or reduce the growth in TME? What has been the result of such efforts?*

RESPONSE:

As noted above in question 2, HMC has implemented many initiatives at maintaining or reducing the overall costs. However, there are many factors that are beyond HMC's control which are causing an increase in cost to the system as a whole, including:

- The use of sitters throughout HMC for its behavioral health patients and those patients that require one-on-one supervision has had a significant impact on cost to HMC. HMC has, over the years, expended a great deal of resources on behavioral health. These patients utilize significant resources in the Emergency Department and throughout the organization. In order to better serve this population, HMC utilizes sitters in conjunction with other professional staff to meet the needs of these patients.
- As a result of its high government payer mix, HMC has had to continue to increase the number of its employed physicians to ensure that services remain available to the community, including primary care (affiliated practice), orthopedic surgeons, general surgeons, gastroenterology, oncology, anesthesia, cardiology and hospitalists, along with the necessary support staff, all of which increase the cost at HMC. However, HMC believes that by providing these services in the local community and increasing access locally, there is an overall reduction in the cost to the community and its citizens.

Health System Integration

5. *How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.*
- a. *Is your organization participating in the Medicare Shared Savings ACO project?*
 - b. *If your organization doesn't feel ready to join any type of ACO, what types of supports or resources would it need to be able to join one?*

RESPONSE:

HMC is not participating in the Medicare Shared Savings ACO project.

HMC is currently conducting an ACO readiness study to evaluate where it is regarding its ability to become and/or who to work with in respect to an ACO. HMC currently is not ready to become an ACO. To that end, the infrastructure will need to be fully developed, the required clinical services must be available and the risks of the covered population must be known up front, not after the fact. ACO's, like all previous global payment systems, may limit services to those who need them to protect profit margins or exclude communities or providers where the age or socioeconomic needs are such that the cost of service is high. ACO's may not necessarily work for the betterment of the patient community as the focus may shift from providing care to increasing the number of members assigned to an ACO, especially under a global payment system.

In order to participate in an ACO, HMC believes that a better understanding of the financial costs needs to be developed. The infrastructure of the ACO needs to be in place up front to ensure success:

- HMC will need to build out the necessary Information Systems infrastructure and staff to be able to monitor and manage the patient population it will be responsible for. HMC will also need to be financially able to assume appropriate risk.
- Clinical services must be available at sustainable prices.
- Understanding the inherent risks of the population to be covered up front, not somewhere down the line.
- The economic needs of the population may have a material impact on the success of an ACO. In a poor community such as Holyoke, the population served may have a greater need for support services which may not be covered by insurance.
- Protection from being excluded from an ACO either by contract or by inadequate rates offered by a market-dominant ACO.

6. *Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, patient outcomes and your organization's performance?*

RESPONSE:

HMC has had some experience with global payments. HMC has participated with a Medicare Advantage plan which was a capitated full-risk contract. This experience taught us that providers need the systems and data to understand the overall health needs of the patient and community. The providers need to understand the clinical and financial issues associated with the patients they are responsible for in order to ensure they are receiving adequate reimbursement or capitation. Any payment system with inadequate reimbursement and lack of timely patient information is destined to fail.

7. *Please comment on how your organization is developing formal arrangements or affiliations with other health care providers to provide care under global contracts or other alternative payment methods.*

RESPONSE:

HMC does not currently have any formal agreement. However, if the issues surrounding the development of an ACO as noted in question 5 could be overcome, HMC has an integrated health care system within its corporate structure which includes primary care, visiting nurse services, behavioral health, outpatient therapeutic services and acute care.

8. *What have been the effects of the recent proliferation of limited or tiered network plans on your organization, with regard to how you evaluate performance internally and patient access to care?*

RESPONSE:

HMC believes that tiered network plans have merit, especially if used to entice patients to seek care at low cost providers. However, the current system for determining a provider's tiering is, in most cases, convoluted and different from payer to payer and, in some cases, from provider to provider within the same practice. In addition, the limited network provisions allow for the exclusion of certain providers, not for quality reasons alone, but for market share reasons as well.

9. *Given the proliferation of risk contracting, to what extent is your organization participating in global contracts that include "atypical" healthcare providers (e.g., behavioral health, oral health, home health care, etc.)? If your organization participates in a risk contract, how are supporting services, such as behavioral health and home health care, addressed?*

RESPONSE:

HMC does not participate in risk contracting.

10. *Are there specific areas of care for which you believe there are critical gaps in quality measurement?*

RESPONSE:

There are no gaps that were identified in the area of quality measures. While the Commonwealth, Federal and private organization require quality data reporting, that reporting often overlaps and covers the vast overall spectrum of hospital quality public reporting. Public reporting of physician and/or practitioner quality remains an area that could be expanded.

11. *Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.*

RESPONSE:

HMC appreciates the work that the Commonwealth has undertaken to transform the health delivery system into one that provides the best possible care at the right time and in the appropriate setting. HMC believes that as we move through this transformation, it is important that reimbursement levels be realistic and adequate to cover the "true" cost of care, plus a reasonable surplus to be reinvested in plant, equipment and staff. In determining reasonable rates, the social economic factors of the area being served by the providers need to be taken into consideration as this can significantly impact the cost of care.

As it relates to cost, HMC believes that there are several areas that need to be or that can be addressed to help reduce costs including:

- Decreasing the administrative burden on providers, i.e. duplicate and unnecessary reporting.
- Developing a uniform billing system used by all payers.

- Eliminating unfunded mandates.
- Developing a uniform definition of observation.
- Have insurance companies responsible for the collection of co-payments and deductibles.
- Develop a uniform credentialing process used by all payers.

EXHIBIT C

Exhibit C - Question 1: For each year 2008 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

RESPONSE:

Annual Operating Margins from 2008 – 2010 as follows:

HMC does not currently have an integrated decision support / cost accounting system which would be necessary in order to calculate the information requested for all payer categories. HMC periodically manually calculates this information to estimate performance using broad estimates as to cost for a specific payer. Due to the limited amount of time provided to respond to this request, it was not possible to manually calculate the information. The overall operating margin analysis derived from the information from the Division of Health Care Finance and Policy (DHFP) based on information provided by HMC from its audited financial statements is presented below.

Hospital: Holyoke Medical Center				
Financial Performance Indicators	FY08	FY09	FY10	FY 11 (1)
Profitability				
Operating Margin	0.99%	0.56%	-0.01%	3.0%
Non-Operating Margin	0.21%	0.06%	0.15%	2.9%
Total Margin	0.78%	.62%	0.14%	2.8%
Operating Surplus (Loss) Total	(\$1,208,919)*	\$657,712*	(\$14,353)*	\$3,611,581*
Surplus (Loss)	(\$951,615)*	\$732,174*	\$159,952*	\$3,489,107*
Liquidity				
Current Ratio	1.47	1.35	1.21	1.13
Days in Accounts Receivable	40	39	37	35
Average Payment Period	51	48	48	66
Solvency/Capital Structure				
Debt Service Coverage	1.4	1.9	1.5	1.26
(Total) [3] Cashflow to Total				
Debt [4]	14.8%	21.5%	17.4%	5.4%
Equity Financing	43.7%	13.2%	4.3%	6.5%
Other				
Total Net Assets	\$29,379,431	\$7,907,219	\$2,465,906	(\$8,742,020)
Assets Whose Use is Limited	\$2,190,335	\$2,364,211	\$2,357,109	\$2,146,671
Net Patient Service Revenue	\$115,986,143	\$111,435,845	\$108,157,652	\$114,545,691

*In addition, the table below reflects the operating margin included in the DHFP analysis adjusted for nonrecurring funds received from the state for the Distressed Hospital Trust Fund, Essential Provider Trust Fund and the Infrastructure and Capacity Grant and Medicare waiver funds.

	Fy2008	FY 2009	FY 2010	FY 2011
Operating Margin	-4.66%	-1.25%	-.76%	-2.7%

(1) Calculated by HMC as FY 11 information not yet available on DHFP website.

Exhibit C - Question 2: Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts (contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk), including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss

coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

RESPONSE:

HMC has limited experience with full risk contracts or contracts with down side risk. HMC has not entered into these types of agreements due to several factors including the lack of:

- available data to monitor patient utilization,
- sufficient members to spread the risk,
- ability to negotiate appropriate budgets due to market share,
- financial reserves to withstand sufficient losses.

HMC participated, along with its PHO, in a full risk contract several years ago, which ended in termination due to significant losses incurred as a result of an insufficient budget set by the insurance company, lack of data and a process for monitoring patient utilization. However, HMC has had some beneficial experience with contracts that included surplus sharing and/or pay-for-performance initiatives. These contracts establish a per member per month budget based on a certain percentage of the premium and allocate those funds across the health service line items based on prior year experience. Members of HMC and its PHO met with representatives of the health insurance company to review various utilization and budget reports as well as reports related to various pay-for-performance targets. HMC believes that this type of contract, if managed correctly, helps to focus on costs, patient utilization and the quality of care for the patients.

For HMC to be in the position to take on down side risk, in addition to having sufficient population to spread the risk and a system to manage the population, HMC would need to be in a financial position with sufficient reserves to be able to withstand a significant loss.

Exhibit C - Question 3: *Please submit a summary table showing your advertising/marketing budget and costs for each year 2008 to present. Please explain and submit supporting documents that show the methodology you use to determine your advertising/marketing budget and costs.*

RESPONSE:

HMC's marketing budget houses the costs for its website, which is hosted by an outside company. The cost varies slightly from year to year, based on updates that may be required, but the average annual cost is about \$32,000. This cost includes non-marketing functions on the website such as job applications, legal disclaimers, etc. The marketing budget also houses the costs for listings in the local Yellow Pages. HMC has not implemented any marketing campaigns in recent years due to cash flow difficulties. A marketing campaign was conducted in 2007-2008. This was an informational campaign for one-day surgeries and the total cost of the campaign was approximately \$280,000. It was undertaken to inform the community of

advances in the anesthesia and surgery capabilities. It included print, radio, limited video and direct mail media. The campaign took place over an eighteen-month timeframe.

HMC has not conducted market research (or consumer perception studies) within the past ten years. There are some expenses in the public relations budget relating to sponsorships of local Little League program books and things of that nature. These expenses are intended to support community good will and are not marketing expenses.

Holyoke Medical Center Marketing Summary

Year	Budget \$	Actual \$
2008	\$353,990	\$343,569
2009	353,990	68,229
2010	88,000	36,992
2011	90,244	55,015

Exhibit C - Question 4: Please explain and submit supporting documents that show (a) trends since 2008 in the proportion of bad debt, as defined by M.G.L. c. 118G, §1, you carry on your total business, (b) your understanding of the factors underlying these trends in bad debt, including but not limited to any role of health insurance plan design, and (c) any changes you have made to your debt collection policies, practices, or expectations in light of these trends.

RESPONSE:

Holyoke Medical Center, Inc.

Bad Debt Write-offs – Summary (Includes HSN)

2011	2010	2009	2008	Total
5,130,602	4,664,068	4,743,360	4,255,843	18,793,873

HMC is seeing an increase in the move toward higher deductible and co-insurance by its patients. This is most likely due to the fact that most employers in the Holyoke area are smaller and, as such, tend to purchase higher deductible and co-insurance plans. As a result of the recent trend in high-deductible, high co-pay plans, HMC has seen an increase in patient bad debts related to these increased co-pays and deductibles. This increase has caused HMC to incur additional administrative costs, in addition to the lost reimbursement, in hiring a third-party vendor that specializes in the collection of self-pay accounts. HMC believes that providers would see a significant decrease in patient bad debts as well as an increase in reimbursement if the insurance companies that are selling these high deductible and high co-payment plans were responsible for their collection. HMC does not accept the argument presented by the health insurance industry that they are not set up to collect these payments since they are already adjudicating these claims and determining the amount owed as well as collecting the premiums associated with these insurance policies.